

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>116</u>	Skilled (SNF)	<u>116</u>	<u>42,340</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>116</u>	TOTALS	<u>116</u>	<u>42,340</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>11,381</u>	<u>4,649</u>	<u>4,719</u>	<u>20,749</u>	8
9	SNF/PED					9
10	ICF	<u>13,084</u>	<u>5,344</u>	<u>1,323</u>	<u>19,751</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,465</u>	<u>9,993</u>	<u>6,042</u>	<u>40,500</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.65%

D. How many bed-hold days during this year were paid by Public Aid? 60 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 06/01/94

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 06/01/94 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 116 and days of care provided 3,515

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **NORTHWOODS CARE CENTRE** # **0044198** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	164,781	9,468	7,226	181,475		181,475	(1,498)	179,977			1
2	Food Purchase		134,786		134,786		134,786	(855)	133,931			2
3	Housekeeping	223,298	29,288		252,586		252,586	(135)	252,451			3
4	Laundry	39,150	15,426	982	55,558		55,558	(816)	54,742			4
5	Heat and Other Utilities			96,010	96,010		96,010		96,010			5
6	Maintenance	8,865	20,232	32,740	61,837		61,837	(527)	61,310			6
7	Other (specify):*			2,977	2,977		2,977		2,977			7
8	TOTAL General Services	436,094	209,200	139,935	785,229		785,229	(3,831)	781,398			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	1,335,486	73,553	24,610	1,433,649		1,433,649	3,677	1,437,326			10
10a	Therapy	16,895		2,399	19,294		19,294		19,294			10a
11	Activities	105,324	10,314	1,222	116,860		116,860	(3,642)	113,218			11
12	Social Services	43,035		798	43,833		43,833		43,833			12
13	Nurse Aide Training			335	335		335		335			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,500,740	83,867	37,164	1,621,771		1,621,771	35	1,621,806			16
	C. General Administration											
17	Administrative	100,549		436,195	536,744		536,744	(426,942)	109,802			17
18	Directors Fees											18
19	Professional Services			113,589	113,589		113,589	10,785	124,374			19
20	Dues, Fees, Subscriptions & Promotions			34,936	34,936		34,936	(22,919)	12,017			20
21	Clerical & General Office Expenses	99,035	26,205	28,258	153,498		153,498	73,223	226,721			21
22	Employee Benefits & Payroll Taxes			402,760	402,760		402,760		402,760			22
23	Inservice Training & Education			2,670	2,670		2,670		2,670			23
24	Travel and Seminar							7,936	7,936			24
25	Other Admin. Staff Transportation			2,335	2,335		2,335		2,335			25
26	Insurance-Prop.Liab.Malpractice			122,667	122,667		122,667	13,787	136,454			26
27	Other (specify):*			15,000	15,000		15,000	(15,000)				27
28	TOTAL General Administration	199,584	26,205	1,158,410	1,384,199		1,384,199	(359,130)	1,025,069			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,136,418	319,272	1,335,509	3,791,199		3,791,199	(362,926)	3,428,273			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	7,226
	REPAIRS & MAINTENANCE		0
			0
			7,226
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		982
			0
			982
5	HEAT & OTHER UTILITIES		
	GAS HEAT		39,027
	ELECTRICITY		32,721
	WATER		23,591
	CABLE TV - LOBBY		671
			0
			96,010
6	MAINTENANCE		
	GROUNDS MAINTENANCE		3,518
	PAINTING & DECORATING		1,623
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		20,300
	ELEVATOR MAINTENANCE & REPAIR		5,378
	OUTSIDE LABOR		1,092
	EXTERMINATING SERVICE		350
	FIRE SERVICE		479
			0
			0
			0
			32,740
7	OTHER		
	SCAVENGER		2,977
	SECURITY SERVICE		0
			2,977
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,800
			7,800

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B 46-2	12,000
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,032
	PHARMACY CONSULTANT	XVIII B 39-2	1,440
	UTILIZATION REVIEW FEES	XVIII B 47-2	7,800
	PHYSICIANS	XVIII B _-2	0
	PSYCHIATRIC	XVIII B _-2	0
	RN CONSULTANT	XVIII B 38-2	2,338
			0
			0
			24,610
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B _-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,651
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	748
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			2,399
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,222
			0
			1,222
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	798
			0
			798
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	335
			335

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 436,195	436,195
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 12,216	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 101,373	
		0	113,589
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 11,164	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 10,698	
	EMPLOYEE WANT ADS	XIX F 2,739	
	CONTRIBUTIONS	VI 20 XIX F 437	
	DUES & SUBSCRIPTIONS	XIX F 6,583	
	LICENSES & PERMITS	XIX F 629	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 87	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 1,531	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 1,068	34,936
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0	
	EQUIPMENT REPAIR & MAINTENANCE	1,871	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 5,965	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	20,344	
	MESSENGER SERVICE	78	
		0	28,258

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 161,127	
	UNEMPLOYMENT COMPENSATION	XIX D 15,868	
	WORKERS COMPENSATION INSURANCE	XIX D 49,698	
	HOSPITALIZATION INSURANCE	XIX D 160,887	
	EMPLOYEE BENEFITS - OTHER	XIX D 5,235	
	EMPLOYEE PHYSICAL EXAMS	XIX D 2,349	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 7,596	
	CHICAGO HEAD TAX	XIX D 0	402,760
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	2,670	2,670
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	2,335	2,335
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	122,667	122,667
27	OTHER		
	BAD DEBTS	VI 24 15,000	
		0	15,000

GRAND TOTAL COLUMN 3 OTHER

1,335,509

NORTHWOODS CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2003

TOTAL FOOD PURCHASE	134,786	PATIENT MEALS	121500
LESS SALES TAX	(855)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	133,931	TOTAL MEALS/YEAR	121500
TOTAL PATIENT CENSUS	40,500	NET FOOD	133931
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	121500

TOTAL PATIENT MEALS	121500	COST PER MEAL	1.1
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			55,330	55,330		55,330	65,128	120,458			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,396	3,396		3,396	248,851	252,247			32
33	Real Estate Taxes			73,881	73,881		73,881		73,881			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(425,406)	12,594			34
35	Rent-Equipment & Vehicles			10,040	10,040		10,040	5,310	15,350			35
36	Other (specify):* STORAGE			1,728	1,728		1,728		1,728			36
37	TOTAL Ownership			582,375	582,375		582,375	(106,117)	476,258			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,877	193,642	295,519		295,519		295,519			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,510	63,510		63,510		63,510			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		101,877	257,152	359,029		359,029		359,029			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,136,418	421,149	2,175,036	4,732,603		4,732,603	(469,043)	4,263,560			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(16,233)	30		9
10	Interest and Other Investment Income	(63,966)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(855)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(5,965)	21		18
19	Entertainment	(11,164)	20		19
20	Contributions	(1,968)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(792)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,000)	27		24
25	Fund Raising, Advertising and Promotional	(10,698)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(87)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(16,055)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (142,783)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(326,260)	PG 6&6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (326,260)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (469,043)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0044198

Report Period Beginning:01/01/2003

Ending:12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (411)	6	1
2	VACATION ACCRUAL	(1,498)	1	2
3	VACATION ACCRUAL	(135)	3	3
4	VACATION ACCRUAL	(816)	4	4
5	VACATION ACCRUAL	(116)	6	5
6	VACATION ACCRUAL	(4,113)	10	6
7	VACATION ACCRUAL	(3,642)	11	7
8	VACATION ACCRUAL	(3,596)	17	8
9	VACATION ACCRUAL	(1,728)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(16,055)		49

Summary B

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		FIRST HEALTH CARE ASSOCIATES, LTD (DIVISION OF FHC ENTERPRISE, INC.)		MANAGEMENT/CONSULTANT
					MORTON GROVE	
				NORTHWOODS HEALTHCARE CENTRE		
					MORTON GROVE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	\$	FHC ENTERPRISES INC.		\$ 7,790	\$ 7,790	1
2	V	17	ADMINISTRATIVE	436,195	MR. BELLOWS OWNS 57% OF THIS FACILITY		12,849	(423,346)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		4,655	4,655	3
4	V	20	DUES & SUBSCRIPTIONS				998	998	4
5	V	21	CLERICAL				80,916	80,916	5
6	V	24	TRAVEL				7,936	7,936	6
7	V	26	INSURANCE				3,969	3,969	7
8	V	30	DEPRECIATION				2,512	2,512	8
9	V	34	RENT				12,594	12,594	9
10	V	35	RENT - EQUIPMENT & VEH				5,310	5,310	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 436,195			\$ 139,529	\$ * (296,666)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 438,000	NORTHWOODS HEALTHCARE CENTRE		\$	\$ (438,000)	15
16	V	26	MORTGAGE INSURANCE		" "		9,818	9,818	16
17	V	30	DEPRECIATION		" "		78,849	78,849	17
18	V	32	AMORTIZATION		" "		52,273	52,273	18
19	V	32	INTEREST - MORTGAGE		" "		241,773	241,773	19
20	V	32	INTEREST - OTHER		" "		18,771	18,771	20
21	V	19	ACCOUNTING		" "		5,750	5,750	21
22	V	19	DATA PROCESSING		" "		1,172	1,172	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 438,000			\$ 408,406	\$ * (29,594)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								\$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	57%	SEE ATTACHED	1.95	8.22	SALARY	12,848	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,848		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number NORTHWOODS CARE CENTRE# 0044198

Report Period Beginning:

01/01/2003Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

FHC ENTERPRISES, INC.

Street Address

8140 RIVER DRIVE

City / State / Zip Code

MORTON GROVE, IL 60053

Phone Number

(847) 583-0100

Fax Number

(847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	493,454	9	\$ 94,929	\$ 94,929	40,500	\$ 7,790	1
2	17	ADMINISTRATIVE	PATIENT DAYS	493,454	9	159,981	159,981	40,500	12,849	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	493,454	9	56,724		40,500	4,655	3
4	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	493,454	9	12,155		40,500	998	4
5	21	CLERICAL	HOURS WORKED	1	1	65,213	65,213	1	65,213	5
6	24	TRAVEL	PATIENT DAYS	493,454	9	96,702		40,500	7,936	6
7	26	INSURANCE	PATIENT DAYS	493,454	9	48,361		40,500	3,969	7
8	30	DEPRECIATION	PATIENT DAYS	493,454	9	30,611		40,500	2,512	8
9	34	RENT	PATIENT DAYS	493,454	9	153,459		40,500	12,594	9
10	35	RENT - EQUIPMENT & VEH	PATIENT DAYS	493,454	9	64,696		40,500	5,310	10
11	21	CLERICAL	PATIENT DAYS	493,454	9	191,338		40,500	15,703	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 974,169	\$ 320,123		\$ 139,529	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	RELATED PARTY - NORTHWOODS HEALTHCARE CENTRE						\$					\$	1		
2	GMAC		X	MORTGAGE		10/97		2,052,500			7.4500	237,260	2		
3	GMAC		X	LOAN COST	AMORT - 35 YEARS			61,456				52,237	3		
4	GMAC		X	MORTGAGE	\$34,916.44	12/03		2,052,500		12/38	5.3500	4,513	4		
5	GMAC		X	LOAN COST	AMORT - 35 YEARS			31,305	31,269			36	5		
	Working Capital														
6	AMERICAN NATIONAL BNK		X	WORKING CAPITAL	VARIES	12/00		975,000		DEMAND	PRIME+	3,396	6		
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	VARIES		173,297		DEMAND	VARIES	18,771	7		
8													8		
9	TOTAL Facility Related				\$34,916.44		\$	5,346,058	\$	31,269			\$	316,213	9
	B. Non-Facility Related*														
10	IRS, IDR, ETC		X	LATE FEES										10	
11														11	
12														12	
13														13	
14	TOTAL Non-Facility Related						\$		\$			\$		14	
15	TOTALS (line 9+line14)						\$	5,346,058	\$	31,269			\$	316,213	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 9,818 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2002 report.	\$	68,544	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	70,821	2	
3. Under or (over) accrual (line 2 minus line 1).	\$	2,277	3	
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	71,604	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	73,881	7	
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	67,231	8	
	1999	67,637	9	
	2000	69,802	10	
	2001	67,798	11	
	2002	70,821	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.				
	FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2002	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

NORTHWOODS CARE CENTRE

COUNTY

BOONE

FACILITY IDPH LICENSE NUMBER

0044198

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	07-01-151-003	NURSING HOME	\$ 70,820.52	\$ 70,820.52
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 70,820.52	\$ 70,820.52

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,500

B. General Construction Type: Exterior BRICK

Frame

Number of Stories 2/BASEMENT

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		1981	\$ 50,050	1
2	754 BASIS ADJ.		1982	4,835	2
3	TOTALS			\$ 54,885	3

Facility Name & ID Number **NORTHWOODS CARE CENTRE**# **0044198**

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	116		1981		\$ 995,068	\$	30	\$ 33,169	\$ 33,169	\$ 762,887	4
5	754 BASIS ADJ		1992		111,968	3,555	31.5	3,555		40,880	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - NORTHWOODS HEALTHCARE CENTRE										9
10	VARIOUS IMPROVEMENTS		1981		4,062		15			4,062	10
11	VARIOUS IMPROVEMENTS		1982		73,451		15			73,451	11
12	VARIOUS IMPROVEMENTS		1983		6,203		15			6,203	12
13	VARIOUS IMPROVEMENTS		1984		11,372		20	569	569	11,097	13
14	PAVING		1986		13,000	653	15		(653)	13,000	14
15	SHOWER		1986		4,151	205	25	166	(39)	2,905	15
16	ROOF		1988		38,383	1,219	31.5	1,219		18,945	16
17	DECORATING		1989		1,921	61	31.5	61		872	17
18	VARIOUS IMPROVEMENTS		1990		10,047	319	31.5	319		4,466	18
19	VARIOUS IMPROVEMENTS		1991		2,683	85	31.5	85		1,188	19
20	VARIOUS IMPROVEMENTS		1992		38,565	1,224	31.5	1,224		13,838	20
21	CARPET		1993		6,854	217	31.5	217		2,321	21
22	DRIVEWAY		1993		1,655	42	39	42		424	22
23	SPRINKMAN SONS		1993		1,525	39	39	39		361	23
24	VARIOUS IMPROVEMENTS		1994		3,137	209	15	209		1,985	24
25	VARIOUS IMPROVEMENTS		1994		170,951	6,216	27.5	6,216		51,607	25
26	DOORS		1995		5,029	129	39	129		1,142	26
27	LANDSCAPING		1996		51,185	1,861	27.5	1,861		13,625	27
28	ROOF REPAIR		1996		20,000	727	27.5	727		5,196	28
29	DRIVEWAY REPAIR		1996		4,775	174	27.5	174		1,212	29
30	CONCRETE RETAINING WALL FOR RAMP		1997		1,500	55	27.5	55		348	30
31	WALLCOVERING/HANDRAIL/FLOOR TILES		1997		46,256	1,682	27.5	1,682		10,537	31
32	DRYWALL/PAINTING/WALLPAPER INSTALLATION		1997		30,000	1,091	27.5	1,091		6,728	32
33	450000-GRAIN UNITS-WATER SOFTENER/COUNTER TOPS		1997		11,248	409	27.5	409		2,514	33
34	THREE WAY OVER BED RESIDENT LIGHTING		1998		12,600	458	27.5	458		2,411	34
35	GARBAGE DISPOSAL-KITCHEN REMODELING		1998		1,189	43	27.5	43		235	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WINDOWS AND AUTO DOOR SYSTEM	1998	\$ 25,000	\$ 909	27.5	\$ 909	\$	\$ 4,810	37
38	WALLCOVERINGS/CARPET/FLOOR TILES/GUARD RAILS	1998	68,941	2,507	27.5	2,507		14,349	38
39	TILES	1998	3,164	115	27.5	115		647	39
40	WOOD FLOORING	1998	4,705	171	27.5	171		933	40
41	COUNTER TOPS	1998	17,763	646	27.5	646		3,521	41
42	ELECTRICAL WIRING	1998	3,675	134	27.5	134		742	42
43	REMODELING - PAINTING/DRYWALL/WALLPAPER	1998	125,000	4,545	27.5	4,545		24,757	43
44	WALLCOVERING/TILES/HAND RAILS	1999	29,035	1,056	27.5	1,056		5,236	44
45	REMODELING-HALLS/REHAB/OFFICES/WASHROOMS	1999	100,000	3,636	27.5	3,636		17,726	45
46	TILES	1999	3,924	143	27.5	143		590	46
47	STAINLESS STEEL WALLS IN THE KITCHEN	1999	2,628	96	27.5	96		396	47
48	REMODELING - ARCHITECTURE	2000	4,000	145	27.5	145		574	48
49	BLACKTOP STRIPPING & SEALING	2000	4,050	270	15	270		945	49
50	AIR THERM HEATERS	2000	34,363	1,249	27.5	1,249		4,112	50
51	SINGLESIDED SANDBLASTED URETHANE SIGNS	2001	2,540	169	15	169		423	51
52	DECORATIVE BRICK WALL AROUND PATIO	2001	2,070	75	27.5	75		203	52
53	FIRE ALARM PANEL	2001	2,388	87	27.5	87		228	53
54	SPEED BUMPS - PARKING LOT	2001	3,600	240	15	240		600	54
55	CARPETING-1ST FLR CRDR, NSG OFFICE, ENTRYWAY	2002	12,079	3,865	5	3,865		6,281	55
56	LOOSE LAID BALLASTED RUBBER ROOF	2002	46,590	1,694	27.5	1,694		2,188	56
57	F & L.A.O SMITH WATER HEATER	2002	4,600	167	27.5	167		216	57
58	FURNISH & INSTALL BOILER	2003	25,591	892	27.5	892		892	58
59									59
60									60
61			ADJ TO SL	33,046			(33,046)		61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,204,484	\$ 76,530		\$ 76,530	\$	\$ 1,144,809	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 484,180	\$ 42,921	\$ 37,979	\$ (4,942)	3-15YRS	\$ 200,493	71
72	Current Year Purchases	22,369	12,409	1,118	(11,291)	3-15 YRS	1,118	72
73	Fully Depreciated Assets	5,633					5,633	73
74	RELATED PARTIES	350,922	4,831	4,831			348,869	74
75	TOTALS	\$ 863,104	\$ 60,161	\$ 43,928	\$ (16,233)		\$ 556,113	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	3,122,473
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	136,691
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	120,458
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(16,233)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,700,922

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$6,498
- Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	1999 DODGE RAM -VAN	\$295.13	\$3,542	17
18					18
19					19
20					20
21	TOTAL		\$295.13	\$3,542	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	\$
13.	/2005	\$
14.	/2006	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☒

90

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☒

☐

40

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 270	\$	\$ 270
2	Books and Supplies		65		65
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 335	\$	\$ 335
10	SUM OF line 9, col. 1 and 2 (e)	\$	335		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 88,437	\$		\$ 88,437	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,644			6,644	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			97,871			97,871	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			690			690	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				82,549		82,549	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, I.V. THERAPY Other (specify):	39-2					19,328		19,328	13
14	TOTAL			\$		\$ 193,642	\$ 101,877		\$ 295,519	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 657,417	\$ 902,385	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 86,134)	584,926	584,926	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,081	1,081	5
6	Prepaid Insurance	33,000	92,861	6
7	Other Prepaid Expenses	10,528	10,528	7
8	Accounts Receivable (owners or related parties)	4,400	6,442	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		517,970	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,291,352	\$ 2,116,193	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,807,528	2,266,761	11
12	Long-Term Investments			12
13	Land		50,050	13
14	Buildings, at Historical Cost		995,068	14
15	Leasehold Improvements, at Historical Cost		1,097,449	15
16	Equipment, at Historical Cost	512,180	549,136	16
17	Accumulated Depreciation (book methods)	(424,998)	(1,719,076)	17
18	Deferred Charges		31,269	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,894,710	\$ 3,270,657	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,186,062	\$ 5,386,850	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 228,374	\$ 180,131	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	137,936	137,936	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,463	59,463	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,473	7,473	31
32	Accrued Real Estate Taxes(Sch.IX-B)		71,604	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO DPA</u>	12,357	12,357	36
37	<u>MANAGEMENT FEES</u>	55,588	55,588	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 501,191	\$ 524,552	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	17,210	456,130	39
40	Mortgage Payable		2,052,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 17,210	\$ 2,508,630	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 518,401	\$ 3,033,182	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,667,661	\$ 2,353,668	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,186,062	\$ 5,386,850	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,109,041	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,109,043	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	810,444	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(240,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) REPLACEMENT TAX	(8,117)	15
16	Other (describe) 2002 DEPRECIATION ADJ.	(3,709)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 558,618	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,667,661	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,479,081	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,479,081	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	63,966	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 63,966	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,543,047	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	785,229	31
32	Health Care	1,621,771	32
33	General Administration	1,384,199	33
	B. Capital Expense		
34	Ownership	582,375	34
	C. Ancillary Expense		
35	Special Cost Centers	295,519	35
36	Provider Participation Fee	63,510	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,732,603	40
41	Income before Income Taxes (line 30 minus line 40)**	810,444	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 810,444	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,087	2,278	\$ 66,232	\$ 29.07	1
2	Assistant Director of Nursing	1,954	2,153	44,676	20.75	2
3	Registered Nurses	13,505	14,545	348,457	23.96	3
4	Licensed Practical Nurses	12,720	13,586	236,117	17.38	4
5	Nurse Aides & Orderlies	52,397	54,863	582,084	10.61	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,580	1,660	16,895	10.18	8
9	Activity Director	1,911	2,086	27,364	13.12	9
10	Activity Assistants	11,303	11,570	77,960	6.74	10
11	Social Service Workers	2,751	3,253	43,035	13.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,731	6,322	76,925	12.17	14
15	Cook Helpers/Assistants	10,647	11,255	87,856	7.81	15
16	Dishwashers					16
17	Maintenance Workers	559	567	8,865	15.63	17
18	Housekeepers	23,943	25,506	223,298	8.75	18
19	Laundry	4,587	4,892	39,150	8.00	19
20	Administrator	1,879	2,086	100,549	48.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,966	6,972	99,035	14.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,888	4,137	57,920	14.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,408	167,731	\$ 2,136,418 *	\$ 12.74	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	182	\$ 7,226	1-3	35
36	Medical Director	72	7,800	9-3	36
37	Medical Records Consultant	16	1,032	10-3	37
38	Nurse Consultant	54	2,338	10-3	38
39	Pharmacist Consultant	192	1,440	10-3	39
40	Physical Therapy Consultant	31	1,651	10a-3	40
41	Occupational Therapy Consultant	12	748	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	19	1,222	11-3	44
45	Social Service Consultant	12	798	12-3	45
46	Other(specify) PSYCHO SOCIAL	96	12,000	10-3	46
47	UTILIZATION REVIEW	72	7,800	10-3	47
48					48
49	TOTAL (lines 35 - 48)	758	\$ 44,055		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number
NORTHWOODS CARE CENTRE

0044198

Report Period Beginning: 01/01/2003

Page 21

Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

SUSAN MEAD

ADMIN

\$ 100,549

0

TOTAL (agree to Schedule V, line 17, col. 1)

\$ 100,549

(List each licensed administrator separately.)

B. Administrative - Other

Description

Amount

FIRST HEALTH CARE

MANAGEMENT FEES

\$ 436,195

TOTAL (agree to Schedule V, line 17, col. 3)

\$ 436,195

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee

Type

Amount

\$

SEE SCHEDULE ATTACHED

113,589

TOTAL (agree to Schedule V, line 19, column 3)

\$ 113,589

(If total legal fees exceed \$2500 attach copy of invoices.)

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 49,698

Unemployment Compensation Insurance

15,868

FICA Taxes

161,127

Employee Health Insurance

160,887

Employee Meals

0

Illinois Municipal Retirement Fund (IMRF)*

EMPLOYEE BENEFITS - OTHER

5,235

EMPLOYEE PHYSICAL EXAMS

2,349

PENSION/PROFIT SHARING PLANS

7,596

CHICAGO HEAD TAX

0

INSURANCE - EXECUTIVE LIFE

0

INSURANCE - EXECUTIVE LIFE VI 21

0

TOTAL (agree to Schedule V, line 22, col.8)

\$ 402,760

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

2,739

Health Care Worker Background Check

1,068

(Indicate # of checks performed)

MARKETING/ADV/PROMO

21,949

TRUST/FRANCHISE/CONTRIB/ETC

1,968

LICENSES & PERMITS

629

DUES & SUBSCRIPTIONS

6,583

MGMT CO ALLOCATION

998

TRUST/FRANCHISE/CONTRIB/ETC

(1,968)

Less: Public Relations Expense

(11,164)

Non-allowable advertising

(10,698)

Yellow page advertising

(87)

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 12,017

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

TRAVEL

0

MANAGEMENT COMPANY ALLOC.

7,936

Seminar Expense

0

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 7,936

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING	06/2000	\$ 2,497	3	\$ 416	\$ 832	\$ 832	\$ 417	\$	\$	\$	\$	\$
2	PAINTING/DECORATING	06/2001	1,571	3		262	524	524	261				
3	PAINTING/DECORATING	06/2003	1,623	3				271	541	541	270		
4													
5													
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16													
17													
18													
19													
20	TOTALS		\$ 5,691		\$ 416	\$ 1,094	\$ 1,356	\$ 1,212	\$ 802	\$ 541	\$ 270	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL. COUNCIL LONG TERM CARE-\$6624
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 590 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 63,510
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees